PLEASE NOTE THAT THE PEDIATRIC PATIENT ASSISTANCE PROGRAM PROVIDES PRODUCT TO FAMILIES IN FINANCIAL NEED.

FINANCIAL NEED IS DEFINED AS INDIGENT, FALLING BELOW THE 200% FEDERAL POVERTY LEVEL, OR EXPERIENCING FINANCIAL HARDSHIP SUCH THAT THE FAMILY CANNOT AFFORD TO PURCHASE THE PRODUCT.

PATIENTS WHO HAVE THE FINANCIAL MEANS TO PURCHASE
THE NESTLÉ PRODUCT
OR
WHO HAVE INSURANCE TO COVER IT
DO NOT QUALIFY.

PLEASE DO NOT SUBMIT APPLICATIONS FOR PATIENTS WHO ARE NOT IN FINANCIAL NEED AS THIS MAY IMPACT NESTLÉ'S ABILITY TO PROVIDE PRODUCT TO PATIENTS WHOSE MEDICAL WELL BEING OR LIFE IS DEPENDENT ON ITS PRODUCTS AND WILL NOT OTHERWISE BE ABLE TO OBTAIN THEM.

2017 PEDIATRIC PATIENT ASSISTANCE PROGRAM

The Pediatric Patient Assistance provides Nestlé products to patients 18 years old and younger (1) who need the products to meet special medically determined nutrient requirements which cannot be achieved by modification of the normal diet alone; and (2) who are undergoing enteral therapy treatment for GI conditions, oncology treatment, with severe failure to thrive, or with advanced Cystic Fibrosis. The % of nutrition required to be met by the Nestlé product is 80% for pediatric patients only. The Pediatric Program offers BOOST® Nutritional Drinks and BOOST® Kid Essentials Nutritionally Complete Drinks, and Alfamino™ Infant and Alfamino™ Junior for patients with CMPA, multiple food allergies or severe malabsorptive conditions.

ELIGIBILITY REQUIREMENTS

The Program is intended to provide product for pediatric patients (1) whose family does not have the financial resources or insurance coverage to pay for the product; and (2) who are tube fed for conditions such as oral motor dysfunction or malabsorption; who are undergoing enteral nutrition therapy; or who require that 80% or more of their caloric intake be met by oral consumption of a Nestlé product due to a diagnosed disease or condition.

In order to help insure that Nestlé HealthCare Nutrition is able to provide products to the patients most in need, patients who use the products as supplements are not eligible.

Please take note of the section of the application asking that the patient's healthcare provider certify that:

- The patient is 18 years old or younger.
- The patient's sole or primary source of nutrition is the requested product (80% - 100% of the patient's caloric needs need to be met by intake of the product).
- The requested product will meet special medically determined nutrient requirements which cannot be achieved by modification of the normal diet alone.
- The patient is unable to pay for or receive reimbursement from any third party payers, including any medical insurance or government healthcare programs, for the product(s) requested.

Nestlé HealthCare Nutrition is unable to ship product to patients who reside outside of the U.S.

Please do not submit applications for patients who do not meet these criteria as this may impact Nestlé HealthCare Nutrition's ability to provide product at no charge to patients whose medical outcome or life is dependent on its products.

How It Works:

- This form must be completed by the patient's healthcare professional. The selected product must be prescribed by the healthcare professional.
- The only products available on the Pediatric Patient Assistance Program are those listed.
- The Pediatric Patient Assistance Program provides approved recipients with 4 - 12 cases of product per year in one shipment, depending on the product (refer to the product list below for quantities offered).
- The approval process usually takes about 48 hours after an application is received.
- The healthcare provider will be notified if the application is denied.
- If the healthcare provider is not notified of denial, the requested products will be delivered to the caregiver/patient via UPS within 2 weeks after approval.

Instructions:

(1) **The form MUST BE filled out in its ENTIRETY to be considered**. All sections must be completed.
(2) **INCOMPLETE APPLICATIONS WILL BE AUTOMATICALLY DENIED.**
(3) The form must be signed by the patient's healthcare provider and the caregiver of the patient.
(4) **DO NOT CALL.** The healthcare professional will be notified if the application is incomplete or denied.

NestléHealthScience

2017 Pediatric Patient Assistance Program

TO BE COMPLETED BY THE PATIENT'S HEALTHCARE PROFESSIONAL – MUST BE FILLED OUT COMPLETELY

Name of Patient: ____ Age of Patient: __________

Please check each box below to certify that (If you cannot certify to each statement, the patient is not eligible):

- ☐ The patient is 18 years of age or younger.
- ☐ The patient's sole or primary source of nutrition is the requested product (**80 - 100% of the patient's caloric needs are met by the requested product**.) Estimated daily caloric need of patient: ___________ % caloric need to be met with requested product: __________
- ☐ The requested product will meet special, medically determined nutrient requirements which cannot be achieved by modification of the normal diet alone.
- ☐ **I am requesting a donation of goods for a person who is indigent, below the 200% Federal Poverty Level, or is experiencing severe financial hardship such that they are unable to pay for the product.**
- ☐ **The patient does not have any other means of paying for the product, including coverage by any medical insurance or government healthcare programs or alternative sources of funding.**
- ☐ There will be no attempt to bill any third party, including without limitation, any federal or state healthcare program, for any products supplied.

Please CIRCLE the product being requested below:

Standard Pediatric Formulas over age 1		(12 cases)
Nutren Junior®	Vanilla	9871616062
Nutren Junior® Fiber	Vanilla	9871677400
Compleat® Pediatric	Unflavored	14240000
Compleat® Pediatric Reduced Calorie	Unflavored	4390038074

Peptide-based Formulas for Pediatrics		(12 cases)
Peptamen Junior®	Vanilla	9871616252
Peptamen Junior® 1.5	Unflavored	9871617363
Peptamen Junior® Fiber	Vanilla	9871660210
Peptamen Junior® with PREBIO™	Vanilla	9871616261
	Chocolate	9871636416

GI Impaired Formulas for Pediatrics		(12 cases)
Vivonex® Pediatric	Powder	12250596

Amino Acid-based Formulas for Pediatrics		
Alfamino™ Infant **(4 cs)**	Powder	12250596
Alfamino™ Junior **(8 cs)**	Powder	12250614

BOOST® Nutritional Drinks		(8 cases)
BOOST® Original	Very Vanilla	4390067438
	Rich Chocolate	4390067538
	Creamy Strawberry	4390067639
BOOST Plus®	Very Vanilla	4390093138
	Rich Chocolate	4390093238
	Creamy Strawberry	4390093331
BOOST® VHC Very High Calorie	Very Vanilla	4390018216

BOOST® Kid Essentials		(8 cases)
BOOST® Kid Essentials	Very Vanilla	33510000
	Rich Chocolate	33520000
	Creamy Strawberry	33530000
BOOST® Kid Essentials 1.5	Very Vanilla	33540000
	Rich Chocolate	33580000
	Creamy Strawberry	33590000
BOOST® Kid Essentials 1.5 with Fiber	Very Vanilla	33500000

Name of Health Care Professional/Profession	
Institution/Office	
Practice Location (mailing address)	
Email Address (for application related correspondence only)	
Phone and Fax Numbers	

Licensed Health Care Professional Signature: ___________________________________ **Date:** ________________

NestlēHealthScience

TO BE COMPLETED BY THE PATIENT'S CAREGIVER – MUST BE FILLED OUT COMPLETELY

Please check each box below to certify that (If you cannot certify to each statement, the patient is not eligible):

- ☐ The patient is 18 years old or younger.
- ☐ **I am indigent, below the 200% Federal Poverty Level, or due to severe financial hardship, am unable to pay for the product.**
- ☐ I have no medical insurance coverage, including Medicare, Medicaid, or WIC, for the product.
- ☐ There will be no attempt to bill any third party, including without limitation, any federal or state healthcare program, for any products supplied.
- ☐ I have read and agree to the Privacy Statement and Authorization set forth below.

Privacy Statement and Authorization: I understand that I am submitting personal health information to Nestlé HealthCare Nutrition for purposes applying to their Patient Assistance Program, and authorize Nestlé to use, maintain and share this information with affiliates and third parties to the extent necessary for evaluation of my application, shipment of any product provided under the Program, and regulatory product tracking requirements.

Please Note: All product determinations must be made by the responsible clinician.

Name (Please Print): ____

Relationship to Patient: ____
(Parent, Relative, Legal Guardian, or other Caregiver)

Caregiver Signature: ______________________________ **Date:** ______________

Name of Patient	
Name of Person Receiving Shipment (if other than Patient)	
Street Address (Product cannot be shipped to a PO number or healthcare professional)	
City, State, Zip Code	
Email Address (for application related correspondence only)	
Phone Number	

Please FAX completed application to	**Nestlé HealthCare Nutrition, Inc.** **FAX No: 1-480-379-5003**
OR MAIL to:	Nestlé HealthCare Nutrition, Inc. Attn: Renae Simmons 2150 E. Lake Cook Road, Suite 800 Buffalo Grove, IL 60089 (847) 808-5300

FOR INTERNAL USE ONLY

Approved _____ **Denied** _____ **Date:** ________________ **By:** ____________________